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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation from 03/29/21 to 04/01/21.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 5 sampled residents (#3, #5) who required staff assistance with toileting. The findings are: 1. Review of Resident #3's current FL-2 dated 12/08/20 revealed: -Diagnoses included Alzheimer's dementia, cerebrovascular accident (CVA) and coronary artery disease (CAD). -Resident #3 was non ambulatory. -Resident #3 was constantly disoriented. -Resident #3 was incontinent with bladder and bowel. Review of Resident #3's care plan dated 03/04/21 revealed: -Resident #3 was incontinent and required staff assistance for toileting needs and hygiene. -Resident #3 used a wheelchair independently.	D 269		

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D 269	Continued From page 1 -Resident #3 needed supervision with transferring. Observation of Resident #3 on 03/30/21 between 1:52pm-2:25pm revealed Resident #3 was sitting in her wheelchair at the nurses' station. Observation of Resident #3 on 03/30/21 at 4:14pm revealed Resident #3 was sitting in her wheelchair at the nurses' station. Observation of Resident #3 on 03/30/21 at 4:31pm revealed: -The personal care aide (PCA) took Resident #3 to the common bath/spa to provide incontinent care. -When the PCA assisted her with standing, the back of Resident #3's pants were soaked with urine and Resident #3's adult incontinence brief was soaked with urine, Interview with the PCA on 03/30/21 at 4:31pm revealed: -Resident #3 was last provided incontinent care before lunch. "I changed her around 12:00pm or 12:30pm." -She usually provided incontinent care to the residents every 2 hours. Interview with a second PCA on 03/31/21 at 9:33am revealed: -She took a 30-minute lunch about 3:30pm yesterday (03/30/21). -She attempted to provide incontinent care for Resident #3 and Resident #3 refused (not sure of the time, "I believe it was before 12:00pm.") Interview with a third PCA on 03/31/21 at 10:55am revealed: -She provided incontinent care for Resident #3.	D 269		

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-Resident #3's adult incontinence brief was soaked with urine in the front.
-She was not sure when Resident #3 was provided incontinent care.

Refer to interview with the Care Manager on 03/31/21 at 9:45am.

Refer to interview with the Administrator on 03/30/21 at 4:36pm.

Refer to interview with the Administrator on 03/31/21 at 3:23pm.

2. Review of Resident #5's current FL-2 dated 01/12/21 revealed:
-Diagnoses included dementia, fall history, mid right low extremity cellulitis.
-Resident #5 was non ambulatory.
-Resident #5 was constantly disoriented.
-Resident #5 was incontinent with bladder and bowel.

Review of Resident #5's care plan dated 03/29/21 revealed:
-Resident #5 was incontinent and required staff assistance for toileting needs and hygiene.
-Resident #5 used a wheelchair independently.
-Resident #5 needed limited assistance with transferring.

Observation of Resident #5 on 03/30/21 between 1:52pm-2:25pm revealed Resident #5 was sitting in her wheelchair at the nurses' station clapping and singing.

Observation of Resident #5 on 03/30/21 at 4:14pm revealed Resident #5 was sitting in her wheelchair at the nurses' station.

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Observation of Resident #5 on 03/30/21 at 4:22pm revealed:
-The personal care aide (PCA) took Resident #5 to the resident's room to provide incontinent care.
-Resident #5's adult incontinence brief was soaked with urine and stool was present inside of the adult incontinence brief.

Interview with a PCA on 03/30/21 at 4:22pm revealed:
-She did not know when incontinent care was last provided to Resident #5.
-She usually provided incontinent care to the residents every 2 hours.
-She was not assigned the 200 hall today to care for Resident #5; she assisted another PCA.

Interview with a second PCA on 03/31/21 at 9:33am revealed:
-She took a 30-minute lunch about 3:30pm yesterday (03/30/21).
-She checked Resident #5 around 1:00pm for incontinent care and Resident #5's adult incontinence was not soiled, so she did not change her.
-Residents were to be checked every 2 hours for incontinent care.

Refer to interview with the Care Manager on 03/31/21 at 9:45am.

Refer to interview with the Administrator on 03/30/21 at 4:36pm.

Refer to interview with the Administrator on 03/31/21 at 3:23pm.

_____

Interview with the Administrator on 03/30/21 at 4:36pm revealed:
-She expected the facility staff to conduct rounds

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D 269	Continued From page 4 every 2 hours and check residents for incontinent care. -Incontinent care included toileting residents every 2 hours. Interview with the Care Manager on 03/31/21 at 9:45am revealed: -She would not know if the facility staff were conducting their rounds every 2 hours and providing incontinent care to the residents. -If the facility staff needed assistance with incontinent care, they should notify her, and she would assist them. -She knew it was difficult for the facility staff to provide incontinent care to the residents every 2 hours because they had other responsibilities. -She expected the facility staff to check the residents every 2 hours to see if their clothes needed to be changed and to provide toileting to the residents. -She walked the hallways to see if residents needed any assistance. Interview with the Administrator on 03/31/21 at 3:23pm revealed: -The PCAs were responsible for providing incontinent care for the residents. -She expected the facility staff to provide incontinent care to the residents every 2 hours and to get to know the residents who had frequent incontinent episodes and provide more care for them, if needed.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in	D 270		

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accordance with each resident's assessed needs, care plan and current symptoms.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 9 residents sampled (#1, #4, #9) including a resident who eloped twice within 4 days resulting in an emergency room (ER) visit for facial abrasions (#9); a resident who had 3 falls with injuries resulting in a fractured left wrist, a head hematoma, and a laceration above the right eye (#1); and a resident who wandered into other residents' rooms resulting in altercations with other residents and the resident being hit by an object and the resident's hand being injured when another resident shut it in the door (#4).

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 60 residents in a special care unit (SCU) facility.

Review of the facility's Identification and Supervision Of Confused/Wandering Resident Policy (not dated)
revealed:
-The facility would identify residents who walked or wheeled around unrestricted and were a threat to leave the facility unattended due to their confusion.
-For pre-admissions screening, the facility would review the FL-2, hospital discharge summary or other written information; and the facility would obtain and review information from family members and responsible persons, and or

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placement agencies regarding any history or the risk of wandering.
-After admissions, safeguard/assessments would include implementing a wandering resident list which would be made available to all staff; informing staff upon admission and as necessary if the potential existed for a resident to wander; performing a reassessment and changing the care plan accordingly when significant change occurred which may indicate the potential for a resident to wander, and monitoring devices used included wander-guard bracelets (alarmed when the resident approached the door) and Care Track bracelets if applicable (GPS tracking device).
-The facility would practice the following environment safeguards: checked door alarms regularly to assure they were working properly; notified all staff when alarms failed and requested to assure extra precautions for residents at risk of wandering; repaired/reactivated alarm system as soon as practicable; and checked the operations of the Mag Lock door security system, window systems and gate systems to ensure proper working order each Monday and Friday.
-Facility checks were documented on the door and window systems by the maintenance person or the designee.
-The checklist was to be sent to management weekly.

1. Review of Resident #4's current FL-2 dated 07/08/20 revealed:
-Diagnoses included vascular dementia, syncope with history of falls, hypertension, benign prostatic hypertrophy, gout, and electrolyte imbalances.
-The resident was constantly disoriented and wandered.
-The resident required personal care assistance with bathing, dressing, and feeding.

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D 270	Continued From page 7 Review of Resident #4's Resident Register dated 07/12/19 revealed: -The resident was admitted to the facility on 07/12/19. -The section for personal assistance required was blank. -The section for orientation and memory was blank. Review of Resident #4's current assessment and care plan dated 07/07/20 revealed: -The resident was always disoriented, wandered, and was hard to redirect at times. -The resident ambulated independently with no assistive devices. -The resident required extensive assistance from staff with toileting, bathing, dressing, and grooming. -The resident was independent with transferring. -There was no documentation of a supervision plan for the resident's wandering behavior. Review of Resident #4's current special care unit (SCU) quarterly profile dated 01/13/21 revealed: -The resident's behavior pattern included being uncooperative. -The resident exhibited sundowning (increased confusion, anxiety, agitation, pacing, and disorientation beginning at dusk and continuing throughout the night). -Interventions listed were to encourage participation in activities, one-on-one activities when needed, and the resident would calm down when given a snack if showing behaviors. -Triggers for pleasant behavior was "staying busy". -The resident required supervision and prompting during meals. -The resident was independent with transferring	D 270		

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and ambulation without assistive devices.
-The resident required extensive assistance from staff with toileting, bathing, dressing, and grooming.

Observation of Resident #4 on 03/29/21 at 2:05pm revealed:
-The resident was lying in bed in his room and said "alright" when spoken to.
-The resident mumbled and talked incoherently.

Review of Resident #4's progress note dated 10/07/20 at 10:16pm revealed:
-Resident #4 got into an altercation with another resident which resulted in Resident #4 getting hit by an object.
-The resident did not appear to have any injuries.
-Staff would continue to closely monitor the resident for any changes.

Telephone interview with a medication aide (MA) on 03/31/21 at 11:55pm
-On 10/07/20, Resident #4 walked into another resident's room (did not recall who) and got into an altercation with the other resident.
-Resident #4 was hit by an object (could not recall what the object was) and she thought Resident #4 was hit on the forehead.

Review of Resident #4's progress note dated 10/08/20 at 2:13pm revealed:
-The resident had been walking around most of the day.
-The staff had to redirect the resident a few times.

Review of Resident #4's progress note dated 10/10/20 at 2:08pm revealed:
-The resident stayed in his room most of the morning then started wandering after lunch.
-Staff would continue to monitor and report any

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changes or concerns.

Review of Resident #4's progress note dated 10/11/20 at 5:37am revealed:
-The resident had been awake all night going into other residents' rooms.
-Staff would continue to monitor him for any new changes.

Review of Resident #4's mental health provider (MHP) visit note dated 01/22/21 revealed:
-Resident #4 paced the halls and went into other residents' rooms.
-The resident was receiving medication for restlessness and agitation.
-Staff reported no acute concerns at this time.

Review of Resident #4's progress note dated 02/05/21 at 2:38pm revealed:
-Resident #4 went into another resident's room and the other resident was trying to shut the door on Resident #4 to keep him out.
-The door was closed on Resident #4's left hand.
-An incident report (not provided) was completed and the primary care provider (PCP) was called.
-Staff was to monitor the resident's hand and report any changes.

Telephone interview with the same MA on 03/31/21 at 11:55pm
-On 02/05/21, Resident #4 wandered into another resident's room (did not recall who) and Resident #4's hand was injured with the door.
-The resident's hand was not bruised or broken and did not require treatment to her knowledge.

Review of Resident #4's progress note dated 02/08/21 at 10:17pm revealed the resident got agitated and would not allow the personal care aide (PCA) to shave him tonight.

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Review of Resident #4's MHP visit note dated 02/16/21 revealed:
-On 02/05/21, Resident #4 went into another resident's room and the other resident tried to shut the door to keep him out and Resident #4's left hand was shut in the door.
-On 02/08/21, Resident #4 got agitated and would not allow staff to shave him.
-Upon visit, the resident was found pacing quietly in the hallway, appeared calm, notably confused, and slow to respond.
-Staff reported no acute concerns at this time.

Review of Resident #4's accident/incident (A/I) report dated 02/23/21 at 12:00pm revealed:
-Resident #4 was in a chair unresponsive in another residents' room.
-The resident was sent to the hospital via emergency medical services (EMS).
-The PCP was at the facility and was notified.
-The resident was diagnosed with seizure and COVID-19
-The resident returned to the facility (date and time not noted) and was put in the COVID-19 unit.
-Increased supervision and monitoring had been initiated.

Review of Resident #4's progress note dated 02/23/21 at 9:23pm revealed:
-The resident returned from the emergency room (ER) at 7:30pm with a diagnosis of COVID-19.
-The resident would be quarantined in a room on the 200 hall.

Review of Resident #4's progress note dated 03/21/21 at 6:47pm revealed:
-The resident had a fall at 4:00pm.
-The PCP and responsible party (RP) were

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notified.

Review of Resident #4's A/I report dated 03/21/21 at 4:09pm revealed:
-The resident had a fall in his room.
-The resident was sitting on his bedroom floor and no injury was noted.
-The PCP and RP were notified.

Review of Resident #4's A/I report dated 03/24/21 at 4:48pm revealed:
-Resident #4 had a fall in another resident's room.
-Resident #4 was sitting on the floor with no injuries.
-The PCP and RP were notified.

Interview with a MA on 03/31/21 at 3:50pm revealed:
-On 03/24/21, she found Resident #4 in another resident's room so she directed him out of the room and sat him in a chair.
-She went to complete some personal care duties and she heard a loud noise.
-Resident #4 was back in the other resident's room and sitting on the floor.
-She and the MA checked Resident #4 but he had no injuries.
-She was concerned the other resident may have pushed Resident #4 causing the fall because the other resident did not want Resident #4 in his room.
-Resident #4 would sometimes grab other residents' arms to try to get the residents to go with him.
-She had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to her.

Review of Resident #4's March 2021 electronic

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medication administration record (eMAR) revealed:
-There was an entry to initiate the Fall Prevention Program and check vital signs for 3 days every shift with shifts being designated as 7:00am - 7:00pm (day shift) and 7:00pm - 7:00am (night shift).
-The 72-hour monitoring of vital signs was documented as completed from 03/21/21 - 03/27/21, with 1 missed shift on 03/21/21 for night shift.

Review of Resident #4's 15-minute supervision check lists for January 2021 - March 2021 revealed:
-There were 15-minute checks documented on 01/10/21 from 4:00pm - 11:45pm.
-There were 15-minute checks documented on 01/11/21 from 12:00am - 3:30pm and 11:00pm - 11:45pm.
-There were 15-minute checks documented on 01/12/21 from 12:00am - 7:00am.
-There were no documented 15-minute checks for February 2021 or March 2021.

Observation on 03/30/21 at 3:44pm revealed Resident #4 was not in his room.

Interview with the PCA assigned to Resident #4's hall on 03/30/21 at 3:44pm revealed:
-He was not sure where Resident #4 was located.
-He had seen the resident in the activity room earlier (could not recall when) or the resident might be in the quiet room.
-He would look for the resident.

Observation on 03/30/21 from 3:44pm - 3:48pm revealed:
-The PCA checked the activity room on the men's hall, the residents' room on the women's hall and

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the middle hall, including the quiet room but could not find Resident #4.
-As the PCA started back down the men's hall at 3:48pm, the MA found Resident #4 in another resident's room and was redirecting Resident #4 to his room.

Observation of Resident #4 on 03/31/21 at 8:12am revealed:
-Resident #4 was in another male resident's room down the hall from his room.
-Resident #4 was lying on the bed near the door with his eyes closed.
-The two male residents who resided in the room were also sitting in the room.

Observation of Resident #4 on 03/31/21 at 9:40am revealed:
-Resident #4 was walking down the hallway when he walked into another resident's room.
-The male resident who resided in the room attempted to stop Resident #4 from entering his room by blocking Resident #4 with his rolling walker.
-Two PCAs redirected Resident #4 and assisted him to his room.

Observation of the men's hall on 04/01/21 at 2:36pm revealed:
-Resident #4 was walking down the hallway, dragging a blanket between his feet.
-Resident #4 attempted to walk into another resident's room (Room #100).
-The Maintenance Director stopped Resident #4 before he could get into the other resident's room.
-The Maintenance Director called for the PCA that was delivering snacks for assistance.
-The PCA redirected Resident #4 and escorted him back to his room down the hallway.

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Observation of the Administrator's office on 04/01/21 at 10:02am revealed:
-Resident #4 walked into the office and picked up a box of paper clips off her desk.
-The Administrator redirected Resident #4 and assisted him back into the hallway.

Confidential staff interview revealed:
-Resident #4 tried to get in bed with female residents.
-Resident #4 would go to sleep in other residents' beds and the PCAs would just let him sleep without redirecting the resident back to his room.
-Resident #4 "got lost" every day and staff would find Resident #4 asleep in another resident's room.

Confidential interview with a second staff revealed:
-Resident #4 would not stay still.
-Staff tried to avoid Resident #4 because they would leave the resident in his room and not check on him.
-Resident #4 would fall asleep in other residents' rooms.
-Residents (male and female) had complained to staff about Resident #4 going into their rooms.
-The residents did not like Resident #4 invading their personal space.
-There was a chair in the middle of the hall for staff to sit in to monitor residents but there was usually no staff in the chair to monitor.

Interview with a home health nurse (HHN) on 03/31/21 at 10:25am revealed Resident #4 wandered and she had observed him in other residents' beds on the men's hall during her visits at the facility.

Interview with a PCA on 03/29/21 at 2:05pm

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revealed:
-Starting about 2:00pm - 3:00pm, Resident #4 was "on the go", walking up and down the halls.
-Resident #4 "loves females" and would go to the women's hall and try to go in their rooms.
-Resident #4 walked up to female residents and tried to get them to go with him.
-The female residents did not like Resident #4 in their rooms.
-He had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to him.
-When Resident #4 went into other residents' rooms, he would help get the resident out of the room sometimes by holding Resident #4's hand and leading him out.
-He could not say how often he supervised Resident #4 but he tried to "keep him close".

Interview with a MA on 03/31/21 at 3:26pm revealed:
-Resident #4 wandered into other residents' rooms and when she saw him doing this, she would redirect him.
-If she found Resident #4 in another resident's room, she would ask him to come out and find something for him to do, like taking him to the quiet room or get him a snack.
-She had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to her.
-Resident #4 was not on any specific time checks for supervision to her knowledge.
-She tried to "lay eyes" on all residents at least every 30 minutes.

Interview with a second MA on 03/31/21 at 3:34pm revealed:
-Resident #4 wandered into other residents' rooms and she would redirect him.

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-Sometimes Resident #4 was easy to redirect and sometimes he was not.
-Most of the time when she found Resident #4 in other residents' rooms, he was either laying down or plundering through the other residents' belongings.
-She had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to her.
-About 1 to 2 months ago (could not recall date), she found Resident #4 in a female resident's (could not recall which resident) room on the women's hall.
-The female resident was asleep in bed and Resident #4 was curled up at the foot of the bed asleep.
-She guided Resident #4 out of the room.
-She had also found Resident #4 in bed with a male resident and both were asleep but she could not recall when or which resident.
-Staff was supposed to "lay eyes" on all residents every 30 minutes but staff could not always do that if they were helping other residents, such as giving showers.
-Staff usually did 15-minute checks for resident's with falls for 72 hours.
-Resident #4 was not on 15-minute checks to her knowledge.

Telephone interview with a third MA on 03/31/21 at 11:55pm
-Resident #4 wandered 50% to 75% of the day.
-Staff would redirect Resident #4 and have him sit in a chair.
-The resident would sit for 3 to 5 minutes and then get up and wander again.
-If the resident was having a "good" day, he would sit for 20 to 30 minutes before he got up again to wander; this only happened about once a week.
-The resident wandered all over the facility and

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she tried to "keep a close eye" on Resident #4.
-The PCAs would let the MAs know if they were helping other residents so the MAs could monitor Resident #4.
-Staff usually did 15-minute checks if a resident had a fall or just came back from the hospital for 3 days.
-Resident #4 was not on 15-minute checks to her knowledge because it would be documented on a log.
-Residents had voiced concerns to her about not wanting Resident #4 in their rooms.
-She had not observed Resident #4 touch anyone inappropriately and no residents had voiced concerns about that.

Telephone interview with a fourth MA on 04/01/21 at 4:33pm revealed:
-Resident #4 tended to wander and argued with other residents.
-Resident #4 wandered into other residents' rooms and the other residents got upset and irritated with Resident #4 because they did not want him in their rooms.
-Resident #4 would crawl in other residents' bed and cuddled up next to the other residents.
-Resident #4 was "everywhere" and it was hard to keep up with Resident #4.
-He checked on Resident #4 "quite regularly" but could not indicate a specific time frame.

Telephone interview with Resident #4's family member on 03/31/21 at 5:50pm revealed:
-Resident #4 could sometimes be aggressive, meaning the resident cursed or tried to jerk away when she helped him get in her car.
-The resident wandered into other residents' rooms at the facility and other residents did not like it.
-Prior to the COVID-19 pandemic, she would visit

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the resident and find him in other residents' room lying in their beds.

Telephone interview with Resident #4's MHP on 04/01/21 at 3:05pm revealed:
-She was aware Resident #4 wandered "a lot" and had to be redirected by staff.
-Resident #4 was prescribed prn medication to help with agitation.
-She expected the facility staff to redirect the resident when he wandered into other residents' rooms and to follow the facility's policies and procedures for supervision of the resident.

Attempted interview with Resident #4's PCP on 04/01/21 at 2:53pm was unsuccessful.

Interview with the Administrator on 04/01/21 at 5:30pm revealed:
-The facility did not currently have a specific list for wandering residents as noted in their supervision policy.
-She and the Care Manager (CM) and sometimes the physical therapist discussed residents who wandered during at-risk meetings.
-She and the CM told staff who the residents who wandered were and staff knew by working with the residents, including Resident #4.
-She would be implementing a list of residents who wandered today, 04/01/21.

Review of the facility's "Wandering Resident List" provided on 04/01/21 at 5:37pm revealed there were 16 residents on the list, including Resident #4.

2. Review of Resident #9's current FL-2 dated 06/01/20 revealed:
-Diagnoses included dementia, hypertension, cardiovascular health, history of stroke,

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rhinorrhea, type 2 diabetes mellitus, gastrointestinal esophageal reflux disorder, chronic pain, history of vitamin D and vitamin B12 deficiency, tinea pedis and poor balance.
-The resident was constantly disoriented
-The resident was semi-ambulatory with rolling walker.
-The resident wandered.
-The resident required staff assistance with bathing and dressing.

Review of Resident #9's progress notes dated 03/09/21 revealed:
-He had eloped from the facility.
-He was found outside on the facility grounds.
-He had no injuries noted.
-Resident #9 was seen by the Primary Care Provider (PCP) on 03/09/21.

Review of Resident #9's Incident/Accident Report dated 03/09/21 at 3:42pm revealed:
-He had eloped from the facility.
-He was found outside on the facility grounds.
-He had little scratches on his right arm and the top of his head.
-He was found by a home health care provider.
-The PCP was in the facility and evaluated him.
-Resident #9's family member was contacted.
-Increased supervision was initiated with 15 minute checks which began at 1:30pm and continued through 03/27/21 was the last documented time received with requested documents.
-The staff was educated on resident elopement.
-The staff was advised to complete door checks frequently during all shifts.
-Door alarm checks were to be done twice a day by maintenance.
-The staff were to monitor him and report any changes.

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D 270	Continued From page 20 Review of Resident #9's Increased Supervision and Accountability Checklist revealed: -Resident #9 was started on 15-minute monitoring beginning on 03/09/21 at 1:30 pm and continued through 03/27/21 was the last documented time received with requested documents. -There was documentation every 15 minutes from 03/09/21 at 1:30pm through 5:00pm on 03/12/21 and resumed at 5:30pm on 03/12/21. Review of Resident #9's Incident/Accident Report dated 03/12/21 at 5:39pm revealed: -He had eloped from the facility. -He was found outside on the facility grounds. -He had a skin tear to his forehead. -He was sent to the local emergency room (ER) via emergency medical services (EMS) for evaluation. -The Primary Care Provider (PCP) was called and had left a message for him. -The ER left a message for a family member. -Resident #9 was scheduled for follow up with the PCP on 03/16/21. Review of Resident #9's ER record dated 03/12/21 revealed: -He was transported to the ER because of an unwitnessed fall during an elopement on 03/12/21. -He had an abrasion to his forehead -His head and cervical spine Computerized Tomography scan were negative for acute processes. -He was discharged from the ER and returned to the facility on 03/12/21. -He was continued on increased supervision with 15-minute monitoring.	D 270		

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Review of Resident #9's Increased Supervision and Accountability Checklist revealed:
-He was on 15-minute monitoring at the time of his elopement on 03/12/21.
-All entries from 12:00am through 4:45pm in 15 minute increments were documented with Resident #9's locations of Bedroom, Hallways 1, 2, and 3, and Front Desk and the initials of the staff member documenting.
-The entry for 4:45pm revealed Resident #9 was in his bedroom.
-The entry for 5:00pm revealed Resident #9's location was other.
-The entry for 5:15pm revealed Resident #9's location was other.
-The key code for "other" was listed as Explain.
-There was no explanation noted for "other" at 5:00pm and 5:15pm.
-The entries for 5:30pm through 10:15pm revealed Resident #9's location was hospital.
-The entry for 10:30pm revealed Resident #9's location was his bedroom.

Review of Resident #9's progress notes revealed:
-There was an entry on 03/09/21 at 3:42pm regarding his elopement.
-The next entry was on 03/12/21 at 3:51pm.

Observation of Resident #9 on 03/31/21 at 9:54am revealed:
-He was at the break room door at the end of the 100 hall and attempted to open the door.
-After several attempts, he walked down the 100 hall and went down the 300 hall and sat in a chair near the dining room door.
-There was no staff noted in the hallways.

Observation of Resident #9 on 03/31/21 at 10:10am revealed:
-He was standing at the nurse's station.

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D 270	Continued From page 22 -He was asked if he wanted to go to his room and was assisted back to his room by the medication aide (MA). Observation of Resident #9 on 03/31/21 at 11:21am revealed: -He was walking down the 300-hall. -He was redirected by a personal care aide (PCA) and assisted back to his room. Observation of Resident #9 on 03/31/21 at 3:07pm revealed: -He was walking down the 100-hall. -He sat in a chair in the hallway on the 100-hall. Interview with a PCA on 03/29/21 at 11:00am revealed: -Resident #9 was hard to keep up with because he was always walking. -He had been moved from room 106 to room 100 to put him closer to the nurse's station and away from the break room. -He had gotten out of the facility twice (not sure of the exact dates). -One time Resident #9 got out through the breakroom door but the PCA was not sure how he got out the second time. -Staff increased monitoring for residents when they eloped. -Residents who eloped were placed on increased supervision with 15-minute checks and those were documented on the 15-minute check sheets. -The break room door did not always shut completely so staff had to pull it shut and double check it. -The alarm on the break room door would not sound if it was not shut completely. -Resident #9 had also tried to climb out of his window (PCA not sure of the date).	D 270		

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-The Maintenance Supervisor had fixed all the windows so they would not open all the way.
-Maintenance also checked and repaired all the exit doors.

Interview with housekeeping staff on 03/30/21 at 11:45am revealed:
-Resident #9 had eloped twice.
-She was not sure of the date but it was within the last 45 days, since that was how long she had worked at the facility.
-Once he got out through the front door.
-He got all the way down to the stop sign (0.2 miles from the facility).
-One of the staff from the facility across the road found him and brought him back.
-The break room door did not always shut so staff had to check behind themselves.
-She was not aware of how he got out the other time nor anything about him attempting to climb out of a window.

Interview with the Maintenance Supervisor on 03/30/21 at 2:40pm revealed:
-He had worked on the exit doors and the alarms to assure they shut and alarmed correctly.
-He had to work on the windows to keep them from opening all the way since Resident #9 had "tried to escape through the window".

Interview with the Resident Care Coordinator on 04/01/21 10:22am revealed:
-She had spoken with Resident #9's family member regarding his elopements.
-She was passing out the evening meal trays on 03/12/21 when Resident #9 was on the 300-hall trying to get the food trays.
-A PCA came and assisted Resident #9 back to his room for dinner.
-Resident #9 had been brought back to the facility

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by a passer-by who had found him in the ditch down by the stop sign (she did not remember the time).
-The first time he eloped on 03/09/21, he was brought back to the facility by a home health nurse.
-The 15-minute checks were started after any elopement.

Interview with Resident #9's mental health care physician's assistant on 04/01/21 at 3:02pm revealed:
-He could be combative.
-She had seen him wander in and out of residents' rooms.
-She was not sure how it was possible for him to elope since the facility was a locked unit.

Attempted interview with Resident #9's family on 03/30/21 at 12:19pm and 04/01/21 at 10:35am were unsuccessful.

Attempted interview with Resident #9's Primary Care Provider on 04/01/21 at 2:53pm was unsuccessful.

Based on observation, interview, and record review, Resident #9 was not interviewable due to diagnoses of Alzheimer's dementia.

3. Review of the facility's fall management program dated 08/16/20 revealed:
-A "Fall Risk Assessment Tool" was completed for all residents admitted to determine factors that may contribute to possible falls.
-The staff completed an "Incident Report" in it's entirely for any fall. Staff were to contact the family/responsible party and the physician.
-The staff completed a 72-hour follow up on the resident's fall to investigate possible

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circumstances contributing to the fall and document observations after the fall of the resident for 72 hours.
-If a resident had 2 falls within a 4-week period, the physician was to be contacted to request an order for a physical therapy (PT) evaluation or other treatment/interventions as applicable.

Review of Resident #1's current FL-2 dated 07/14/20 revealed:
-Diagnoses included dementia, muscle weakness, hypothyroidism, major depressive disorder, pulmonary heart disease, cataracts, history of left hip fracture, and gastrointestinal bleed.
-Orientation status was constantly disoriented.
-Ambulatory status was non-ambulatory.

Review of Resident #1's Care Plan dated 06/17/20 revealed:
-She was ambulatory with staff assistance or device-wheelchair.
-She required limited assistance with ambulation/locomotion.

Review of Resident #1's Licensed Health Professional Support (LHPS) review and evaluation completed on 12/31/20 revealed:
-She required assistance with transferring.
-She was able to self-propel in her wheelchair.

Review of a physician Consultation Note for Resident #1 dated 12/08/20 revealed:
-Resident #1 remained a fall risk.
-Resident #1 required transfer assistance as needed and should continue consistent use of wheelchair.

Observation of Resident #1 on 03/29/21 from 1:54pm until 2:39pm revealed:

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-She was sleeping in bed, with her back towards the wall and her left arm on a pillow.
-There was a fall mat folded up next to the dresser.
-There was no fall mat by the resident's bed.

Observation of Resident #1 on 03/30/31 from 10:15am until 11:07am revealed:
-She was sleeping in bed.
-There was a fall mat folded up next to the dresser.
-There was no fall mat by the resident's bed.

a. Review of an Accident/Incident Report dated 02/18/21 revealed:
-Resident #1 was found on the floor on her fall mat.
-She had a 'knot on the back of her head'.
-She was sent to the emergency room (ER) for treatment and returned to the facility.

Review of Resident #1's hospitalization records dated 02/18/21 revealed a computed tomography (CT) scan showed a left posterior head hematoma.

Interview with a personal care aide (PCA) on 03/31/21 at 11:15am:
-Resident #1 had a fall mat for over a year.
-Anytime Resident #1 was in her bed, the fall mat was to be placed next to the bed.
-When residents returned from the hospital with a fall, they were to be placed on increased supervision with 15 minute checks.

Interview with the Care Manager (CM) on 03/30/21 at 4:38pm revealed:
-Resident #1 had a fall mat ordered.
-When Resident #1 returned from the ER on 02/18/21 after her fall, she was placed on the fall

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prevention program where vital signs were monitored three times a day for three days.
-Residents were monitored for any bruising, pain related to the fall and change in mental status for 72 hours after a fall.

b. Review of an Accident/Incident Report dated 03/03/21 revealed:
-Resident #1 had a witnessed fall while in the shower.
-She had left arm pain.
-She was sent to the ER for treatment and returned to the facility.

Review of Resident #1 hospitalization records dated 03/03/21 revealed x-rays completed showed impacted distal radius and ulnar fractures to her left wrist.

Telephone interview with a medication aide (MA) on 03/31/21 at 7:30pm revealed:
-A PCA had Resident #1 in the shower room for her scheduled shower.
-The PCA was normally on the men's hallway but because of the facility rearranging to care for residents who tested positive for COVID-19, staff was moved to different halls.
-The PCA had turned her back to get an incontinent pad and while her back was turned, Resident #1 attempted to move from the shower chair back to her wheelchair.
-Resident #1 required one person assistance for showering and dressing.

Interview with the Care Manager (CM) on 03/30/21 at 4:38pm revealed:
-Resident #1 required one person assistance for personal care including showering.
-When Resident #1 returned from the ER on 03/03/21 after her fall, she was placed on the fall

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prevention program where vital signs were monitored three times a day for three days.
-Residents were monitored for any bruising, pain related to the fall and change in mental status for 72 hours after a fall.

c. Review of an Accident/Incident Report dated 03/12/21 revealed:
-Resident #1 was found on the floor in her room.
-She had a laceration above her right eye.
-She was sent to the ER for treatment and returned to the facility.

Telephone interview with a former staff member on 03/31/21 at 3:45pm revealed:
-She found Resident #1 in her room, when she fell on 03/12/21.
-Resident #1's fall mat was not correctly positioned; it was down towards the bottom of the bed.
-Resident #1's head hit the linoleum floor where the fall mat should have been placed.
-She saw fall mats throughout the facility, but they were rarely placed properly or used at all.

Review of Resident #1 hospitalization records dated 03/12/21 revealed her right eye laceration was treated with an adhesive closure solution.

Interview with a PCA on 03/30/21 3:35pm revealed:
-Resident #1 was to have her fall mat in place anytime she was in the bed.
-Staff placed her wheelchair close to the bed, in case she tried to transfer by herself and staff was not there to assist her.
-During orientation, she was trained on how to put fall mats in place and which residents required a fall mat.

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D 270	Continued From page 29 Interview with the Care Manager (CM) on 03/30/21 at 4:38pm revealed: -Staff was trained on proper use of a fall mat during new hire orientation which included placing the mat parallel to the residents bed from the top of the bed to the bottom. -When Resident #1 returned from the ER on 03/12/21 after her fall, she was placed on the fall prevention program where vital signs were monitored three times a day for three days. -She was also placed on increased supervision which included documented checks every 15 minutes. -Residents were monitored for any bruising, pain related to the fall and change in mental status for 72 hours after a fall. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/01/21 at 2:53pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to provide supervision for 3 of 9 residents sampled (#1, #4, #9) in the facility which was licensed as a special care unit for residents with dementia. Resident #9 eloped twice within 4 days, on 03/09/21 and 03/12/21, was found at the end of the road at a stop sign approximately 0.2 miles from the facility on 03/12/21 and required treatment in the emergency room (ER) for facial abrasions; staff were not using or placing Resident #1's fall mat in the correct position and the resident had 3 falls with injuries requiring ER visits including a fractured left wrist, head hematoma, and laceration above the right eye; and Resident #4 wandered into other residents' rooms and slept in	D 270		

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D 270	Continued From page 30 their beds resulting in arguments and altercations with other residents resulting in Resident #4 being hit by an object on one occasion and Resident #4's left hand being injured when the resident was attempting to enter another resident's room on another occasion. The failure of the facility to provide supervision resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/30/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 1, 2021.	D 270		
D 323	10A NCAC 13F .0906 (c) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services (c) Laundry. (1) Laundry services shall be provided to residents without any additional fee; and (2) It is not the home's obligation to pay for a resident's personal dry cleaning. The resident's plans for personal care of clothing shall be indicated on Form DSS-1865, the Resident Register. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the residents' laundry was completed on each shift. The findings are:	D 323		

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D 323	Continued From page 31 Observation of the laundry room on 03/31/21 at 10:50am revealed: -There were several linens, not in a bag that belong to residents stacked on top of bags of soiled residents' clothes and linens in the laundry room's closet. -There were several bags of residents' clothes stored in the laundry room closet. -There was no identifier to determine which resident the clothes belonged to. Interview with the laundry attendant on 03/31/21 at 10:04am revealed: -She completed 4 or 5 residents' laundry per day. -She was expected to do the laundry of the residents on the same day as their shower days. -It was difficult for her to follow the schedule of the residents' shower days because she only worked Monday through Friday from 8:00am to 1:30pm and there were multiple residents who received showers daily. -She did not like mixing the residents' laundry together unless the residents were roommates and the laundry was not soiled. -She expressed to the Administrator and the Business Office Manager it was difficult for her to complete the residents' laundry as scheduled. -The facility staff were responsible for completing laundry at night. "They help out when they have enough people scheduled." Interview with a personal care aide (PCA) on 03/29/21 at 3:36pm revealed: -There was a laundry attendant dedicated to do laundry Monday through Friday. -Residents laundry was done on their shower days. Interview with a housekeeping staff on 04/01/21 at 10:41am revealed:	D 323		

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-A lot of the laundry came from the night shift.
-The night shift staff were supposed to help with the laundry.
-The Housekeeping Supervisor had spoken with the Administrator, during a staff meeting, requesting at least a part time staff to help with laundry.

Interview with a medication aide (MA) on 03/31/21 at 7:30pm revealed:
-She worked night shift as a MA from 7:00pm to 7:00am.
-Two MAs were scheduled on night shift.
-After the bedtime medication pass, one of the MAs would become a PCA to help provide resident care and the other MA would be responsible for medication administration for the rest of the evening.
-The MA that stayed on the cart all night providing medication administration was responsible for laundry throughout the night.
-Residents' laundry was done on their shower days.
-Large bags in the laundry room were from residents' shower days.
-Small bags in the laundry room were from residents that PCAs provided incontinence care to and their clothing needed laundering.
-She was able to complete laundry throughout the night, but laundry was never truly "caught up".

Interview with the Housekeeping Supervisor on 03/31/21 at 2:57pm revealed:
-He was responsible for the residents' laundry services.
-He expected all residents to have their laundry cleaned and smelling good.
-He had problems with residents' laundry being completed in the evenings and on the weekends.
-He was not aware of the scheduled process for

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D 323	Continued From page 33 residents' laundry to be done on their shower days. -He thought residents' laundry was done based on whatever was available in the laundry room. -If the facility staff were not able to complete the residents' laundry at night, he would complete the residents' laundry or whoever was available would complete the laundry. -The manager on duty was responsible for ensuring the residents' laundry was done during the evenings and at night. Interview with the Administrator on 03/31/21 at 3:33pm revealed: -The laundry attendant worked Monday through Friday from 8:00am to 1:30pm. -PCAs were responsible for taking residents' laundry into the laundry room. -The PCA/floater was responsible for starting the residents' laundry between 8:00pm and 9:00pm and the laundry was expected to be completed later the same night. -She expected facility staff to complete residents' laundry on the residents' shower days. -She was aware the facility staff at night were not always completing their laundry duties. -She knew when the facility staff at night did not complete the residents' laundry, it made it difficult for the laundry attendant to complete her laundry duties during the day "because it was putting her behind." -She expected the laundry attendant to follow the daily schedule for the residents' laundry and notify her if the residents' laundry from the previous night had not been done.	D 323		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders	D 344		

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D 344	Continued From page 34 (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#4) who had orders to receive a controlled substance used to treat anxiety and agitation on a scheduled and prn (as needed) basis resulting in the resident receiving doses too close together. The findings are: Review of Resident #4's current FL-2 dated 07/08/20 revealed: -Diagnoses included vascular dementia, syncope with history of falls, hypertension, benign prostatic hypertrophy, gout, and electrolyte imbalances. -The resident was constantly disoriented and wandered. -There was an order for Lorazepam 0.5mg take 1 tablet twice daily for agitation/anxiety. (Lorazepam is a controlled substance used to treat anxiety and agitation.)	D 344		

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Review of Resident #4's physician's orders dated 11/24/20 revealed:
-There was an order for Lorazepam 0.5mg take 1 tablet twice daily for agitation/anxiety.
-There was an order for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.

Review of Resident #4's January 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-The scheduled Lorazepam was documented as administered twice daily from 01/01/21 - 01/31/21.
-There was an entry for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-The prn Lorazepam was documented as administered on 4 occasions from 01/01/21 - 01/31/21.
-The prn Lorazepam was documented as administered on 01/06/21 at 2:09pm, 01/09/21 at 8:54am, 01/11/21 at 3:28pm, and 01/27/21 at 8:53am.
-All the prn Lorazepam doses were documented as being administered for "behavior issue" and all were documented as "SE" (somewhat effective).

Review of Resident #4's January 2021 controlled substance (CS) log for Lorazepam revealed:
-There were 62 doses of scheduled Lorazepam 0.5mg twice daily documented as administered from 01/01/21 - 01/31/21.
-There were 4 doses of prn Lorazepam 0.5mg documented as administered from 01/01/21 - 01/31/21.
-One prn dose of Lorazepam was documented as

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administered on 01/09/21 at 8:54am, 1 minute after the scheduled dose was documented as administered at 8:53am.
-One prn dose of Lorazepam was documented as administered on 01/27/21 at 8:52am, 1 minute before the scheduled dose was documented as administered at 8:53am.

Review of Resident #4's February 2021 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-The scheduled Lorazepam was documented as administered twice daily from 02/01/21 - 02/28/21.
-There was an entry for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-The prn Lorazepam was documented as administered on 5 occasions from 02/01/21 - 02/28/21.
-The prn Lorazepam was documented as administered on 02/01/21 at 9:04am, 02/03/21 at 9:18am, 02/12/21 at 10:42am, 02/15/21 at 9:12am, and 02/16/21 at 12:42pm.
-All the prn Lorazepam doses were documented as being administered for "behavior issue".
-Three doses were documented as "SE" (somewhat effective) and two doses were documented as "NE" (not effective).

Review of Resident #4's February 2021 CS log for Lorazepam revealed:
-There were 56 doses of scheduled Lorazepam 0.5mg twice daily documented as administered from 02/01/21 - 02/28/21.
-There were 5 doses of prn Lorazepam 0.5mg documented as administered from 02/01/21 - 02/28/21.

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-One prn dose of Lorazepam was documented as administered on 02/01/21 at 9:04am, 8 minutes after the scheduled dose was documented as administered at 8:56am.
-One prn dose of Lorazepam was documented as administered on 02/03/21 at 9:18am, 21 minutes after the scheduled dose was documented as administered at 8:57am.
-One prn dose of Lorazepam was documented as administered on 02/01221 at 10:42am, 1 hour and 51 minutes after the scheduled dose was documented as administered at 8:51am.
-One prn dose of Lorazepam was documented as administered on 02/15/21 at 9:12am, 33 minutes after the scheduled dose was documented as administered at 8:39am.
-One prn dose of Lorazepam was documented as administered on 02/16/21 at 12:42pm, 3 hours and 12 minutes after the scheduled dose was documented as administered at 9:30am.

Review of Resident #4's March 2021 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-The scheduled Lorazepam was documented as administered twice daily from 03/01/21 - 03/28/21.
-There was an entry for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-The prn Lorazepam was documented as administered on 4 occasions from 03/01/21 - 03/28/21.
-The prn Lorazepam was documented as administered on 03/13/21 at 2:38pm, 03/23/21 at 3:43pm, and 03/28/21 at 8:07am and 6:10pm.
-All the prn Lorazepam doses were documented as being administered for "behavior issue".

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-One dose was documented as "E" (effective); two doses were documented as "SE" (somewhat effective); and one dose as "NE" (not effective).

Review of Resident #4's March 2021 CS log for Lorazepam revealed:
-There were 56 doses of scheduled Lorazepam 0.5mg twice daily documented as administered from 03/01/21 - 03/28/21.
-There were 4 doses of prn Lorazepam 0.5mg documented as administered from 03/01/21 - 03/28/21.
-One prn dose of Lorazepam was documented as administered on 03/28/21 at 8:07am, 2 minutes after the scheduled dose was documented as administered at 8:05am.
-A second prn dose of Lorazepam was documented as administered on 03/28/21 at 6:10pm, 3 hours and 31 minutes before the scheduled dose was documented as administered at 9:41pm.
-The resident received 4 doses of Lorazepam 0.5mg on 03/28/21 at 8:05am, 8:07am, 6:10pm, and 9:41pm.

Review of Resident #4's progress note dated 03/28/21 at 9:32pm revealed:
-The resident was found unresponsive by the medication aide (MA) and personal care aide (PCA).
-Emergency Medical Services (EMS) was called and the resident was transported to the hospital.

Review of Resident #4's accident/incident (A/I) report dated 03/28/21 at 9:06pm revealed:
-The resident was sitting in a chair in the hallway unresponsive.
-The resident was pale and drooling.
-The resident was taken to the emergency room (ER) by EMS at 8:50pm.

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-The primary care provider (PCP) and responsible party (RP) were notified.

Review of Resident #4's ER visit notes dated 03/28/21 revealed:
-When EMS arrived to the facility, the resident was found sitting in a chair in the hallway near the front desk and the resident was not alert.
-Facility staff stated the resident was on his feet and active at 7:30pm, exhibiting normal behavior, then he sat down and appeared to go to sleep around 8:00pm.
-Some 15 to 30 minutes later, they tried to wake the resident to put him to bed but he was unresponsive and staff could not wake him up.
-EMS noted the resident was sitting with his hands in his lap, his head slumped forward, diaphoretic (sweating heavily), and drooling onto the front of his shirt.
-The resident's blood sugar and respirations were normal but his blood pressure was low.
-The resident arrived to the ER at 9:32pm with chief complaint of being unresponsive.
-According to hospital records, the resident had a history of seizures and it was suspected he could have had an unwitnessed seizure.
-The resident "likely" had seizure activity and had chronic kidney disease.

Telephone interview with a MA on 04/01/21 at 4:33pm revealed:
-He thought he could administer Resident #4's prn Lorazepam at the same time as the scheduled Lorazepam dose because it was "not a very strong dose".
-He knew about medication doses because he worked at a hospice center and Resident #4's dosage was low compared to some of the dosages at the hospice center.
-Resident #4 tended to wander and argued with

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other residents.
-Resident #4 would crawl in other residents' bed and cuddled up next to the other residents.
-Resident #4 was "everywhere" and it was hard to keep up with Resident #4.
-When he administered the prn and scheduled Lorazepam at the same time or close together, it was because the resident was "up and doing a lot".
-He tried to keep Resident #4 as calm as he could.
-He never had any issues with administering the prn and scheduled Lorazepam at the same time.
-Resident #4 had taken other medications too, and "there was no taking him down with those meds".
-It calmed the resident down and he would finally rest; it made the resident safer, "why not give it".
-On 03/28/21, he administered prn Lorazepam and the scheduled Lorazepam at the same time that morning; then he administered another prn Lorazepam at 6:10pm because the resident "started acting out".
-Resident #4 wandered into other residents' rooms and the other residents got upset and irritated with Resident #4 because they did not want him in their rooms.
-He was not working on the night of 03/28/21 when Resident #4 was found unresponsive.

Telephone interview with a second MA on 03/31/21 at 11:55pm revealed:
-On 03/28/21, Resident #4 had been sitting in a chair in the hallway near the Administrator's office.
-She and a PCA found Resident #4 unresponsive during evening shift on 03/28/21 (could not recall time).
-About 10 minutes before she and a PCA found the resident unresponsive, the resident was alert

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and sitting in the chair.
-The resident was "pale and clammy".
-The resident's eyes were closed and his head was down.
-They called the resident's name but he did not respond.
-She could not get a blood pressure reading with the blood pressure machine and she could not get an oxygen reading with the pulse oximeter.
-She called 911 and EMS came and took the resident to the ER.

Attempted telephone interview on 04/01/21 at 5:00pm with the MA who documented the prn Lorazepam dose on 03/28/21 at 9:41pm was unsuccessful.

Telephone interview with Resident #4's family member on 03/31/21 at 5:50pm revealed:
-Resident #4 had to be sent to the hospital on Sunday night, 03/28/21, because he was unresponsive.
-The hospital provider thought the resident had a seizure on 03/28/21 and on one other occasion in February 2021.
-That was unusual for the resident as he did not have a history of seizures prior to the possible seizure in February 2021.

Interview with the Care Manager (CM) on 04/01/21 at 11:40am revealed:
-She and the MAs were responsible for clarifying medication orders.
-She would expect the MAs to administer Resident #4's prn Lorazepam no sooner than every 4 to 6 hours from the scheduled Lorazepam dosage.
-She was not aware the MAs had administered Resident #4's prn Lorazepam immediately after or before the scheduled Lorazepam dosage.

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D 344	Continued From page 42 -She would contact Resident #4's mental health provider (MHP) to clarify the Lorazepam orders. Interview with the Administrator on 04/01/21 at 5:30pm revealed: -She was not aware the MAs were administering Resident #4's prn Lorazepam and scheduled Lorazepam "back to back". -The prn Lorazepam should not be administered for "hours" after a scheduled dose of Lorazepam. -The MAs should have given the scheduled dose of Lorazepam time to help with the resident's anxiety before administering a prn dose. -The CM or MAs should contact the provider for clarification of medication orders. Telephone interview with Resident #4's MHP on 04/01/21 at 3:05pm revealed: -Resident #4 wandered "a lot" and had to be redirected by staff. -Resident #4 was prescribed prn Lorazepam to help with agitation. -The MAs should wait at least 4 to 6 hours after a scheduled dose of Lorazepam was administered before administering prn Lorazepam if needed. -She was not aware Resident #4 was receiving prn Lorazepam so close to the scheduled doses of Lorazepam. -The MAs were not supposed to do that; the MAs knew it was a 4-hour window (according to the prn order). -Administering the scheduled Lorazepam and the prn Lorazepam too close together put the resident at risk of side effects such as sedation. -She was not aware staff administered 4 doses of Lorazepam to Resident #4 on 03/28/21 when he was found unresponsive by staff. -Resident #4 had no documented history of seizures and Lorazepam was generally used to treat seizures.	D 344		

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D 344	Continued From page 43 -It was concerning that the resident was found unresponsive after the 4 doses of Lorazepam on 03/28/21 because too much Lorazepam could cause the resident to have low blood pressure, low heart rate, and sedation. -No one from the facility contacted her prior to today, 04/01/21, to clarify the Lorazepam orders. -She would revise the Lorazepam orders and lower the dosage that could be administered each day to the resident. Review of a clarification order from Resident #4's MHP dated 04/01/21 revealed: -There was an order to discontinue Lorazepam 0.5mg take 1 tablet every 4 hours prn agitation. -There was an order to start Lorazepam 0.5mg take 1 tablet every 24 hours as needed for agitation (can give for agitation 6 hours after the scheduled dose = not to exceed 1 prn dose in a 24-hour period). -Staff was to monitor for sedation effect, gait disturbances, and contact the MHP immediately. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. _____ The facility failed to ensure clarification of medication orders for 1 of 5 residents sampled (#4) for a controlled substance used to treat anxiety and agitation. Resident #4 had orders for scheduled and prn (as needed) Lorazepam and received prn Lorazepam and scheduled Lorazepam at the same time on several occasions; and he received 4 doses of Lorazepam on 03/28/21 at 8:05am, 8:07am, 6:10pm, and 9:41pm and the resident was found unresponsive with a low blood pressure on the night of 03/28/21 and was sent to the hospital and noted to "likely" have had a seizure. Resident	D 344		

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D 344	Continued From page 44 #4's mental health provider was concerned receiving Lorazepam doses would cause the resident to have side effects such as low blood pressure, low heart rate, and sedation. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/01/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2021.	D 344		
D 350	10A NCAC 13F .1002 (g) Medication Orders 10A NCAC 13F .1002 Medication Orders (g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication; (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period This Rule is not met as evidenced by: Based on observations, interviews, and record	D 350		

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reviews, the facility failed to ensure psychotropic medications ordered prn (as needed) for 1 of 1 sampled residents (#4) included the maximum dosage to be administered in a 24-hour period for a controlled substance used to treat anxiety and agitation.

The findings are:

Review of Resident #4's current FL-2 dated 07/08/20 revealed:
-Diagnoses included vascular dementia, syncope with history of falls, hypertension, benign prostatic hypertrophy, gout, and electrolyte imbalances.
-The resident was constantly disoriented and wandered.
-There was an order for Lorazepam 0.5mg take 1 tablet twice daily for agitation/anxiety.
(Lorazepam is a controlled substance used to treat anxiety and agitation.)

Review of Resident #4's physician's orders dated 11/24/20 revealed:
-There was an order for Lorazepam 0.5mg take 1 tablet twice daily for agitation/anxiety.
-There was an order for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-There was no maximum dosage to be administered in a 24-hour period included in the prn Lorazepam order.

Review of Resident #4's January 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-The scheduled Lorazepam was documented as administered twice daily from 01/01/21 -

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01/31/21.
-There was an entry for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-There was no maximum dosage of prn Lorazepam documented on the eMAR.
-The prn Lorazepam was documented as administered on 4 occasions from 01/01/21 - 01/31/21.
-The prn Lorazepam was documented as administered on 01/06/21 at 2:09pm, 01/09/21 at 8:54am, 01/11/21 at 3:28pm, and 01/27/21 at 8:53am.

Review of Resident #4's January 2021 controlled substance (CS) log for Lorazepam revealed:
-There were 62 doses of scheduled Lorazepam 0.5mg twice daily documented as administered from 01/01/21 - 01/31/21.
-There were 4 doses of prn Lorazepam 0.5mg documented as administered from 01/01/21 - 01/31/21.
-One prn dose of Lorazepam was documented as administered on 01/09/21 at 8:54am, 1 minute after the scheduled dose was documented as administered at 8:53am.
-One prn dose of Lorazepam was documented as administered on 01/27/21 at 8:52am, 1 minute before the scheduled dose was documented as administered at 8:53am.

Review of Resident #4's February 2021 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-The scheduled Lorazepam was documented as administered twice daily from 02/01/21 - 02/28/21.
-There was an entry for Lorazepam 0.5mg take 1

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tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-There was no maximum dosage of prn Lorazepam documented on the eMAR.
-The prn Lorazepam was documented as administered on 5 occasions from 02/01/21 - 02/28/21.
-The prn Lorazepam was documented as administered on 02/01/21 at 9:04am, 02/03/21 at 9:18am, 02/12/21 at 10:42am, 02/15/21 at 9:12am, and 02/16/21 at 12:42pm.

Review of Resident #4's February 2021 CS log for Lorazepam revealed:
-There were 56 doses of scheduled Lorazepam 0.5mg twice daily documented as administered from 02/01/21 - 02/28/21.
-There were 5 doses of prn Lorazepam 0.5mg documented as administered from 02/01/21 - 02/28/21.
-One prn dose of Lorazepam was documented as administered on 02/01/21 at 9:04am, 8 minutes after the scheduled dose was documented as administered at 8:56am.
-One prn dose of Lorazepam was documented as administered on 02/03/21 at 9:18am, 21 minutes after the scheduled dose was documented as administered at 8:57am.
-One prn dose of Lorazepam was documented as administered on 02/01221 at 10:42am, 1 hour and 51 minutes after the scheduled dose was documented as administered at 8:51am.
-One prn dose of Lorazepam was documented as administered on 02/15/21 at 9:12am, 33 minutes after the scheduled dose was documented as administered at 8:39am.
-One prn dose of Lorazepam was documented as administered on 02/16/21 at 12:42pm, 3 hours and 12 minutes after the scheduled dose was documented as administered at 9:30am.

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Review of Resident #4's March 2021 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-The scheduled Lorazepam was documented as administered twice daily from 03/01/21 - 03/28/21.
-There was an entry for Lorazepam 0.5mg take 1 tablet every 4 hours prn (as needed) for anxiety in addition to scheduled dosing twice daily.
-There was no maximum dosage of prn Lorazepam documented on the eMAR.
-The prn Lorazepam was documented as administered on 4 occasions from 03/01/21 - 03/28/21.
-The prn Lorazepam was documented as administered on 03/13/21 at 2:38pm, 03/23/21 at 3:43pm, and 03/28/21 at 8:07am and 6:10pm.

Review of Resident #4's March 2021 CS log for Lorazepam revealed:
-There were 56 doses of scheduled Lorazepam 0.5mg twice daily documented as administered from 03/01/21 - 03/28/21.
-There were 4 doses of prn Lorazepam 0.5mg documented as administered from 03/01/21 - 03/28/21.
-One prn dose of Lorazepam was documented as administered on 03/28/21 at 8:07am, 2 minutes after the scheduled dose was documented as administered at 8:05am.
-A second prn dose of Lorazepam was documented as administered on 03/28/21 at 6:10pm, 3 hours and 31 minutes before the scheduled dose was documented as administered at 9:41pm.
-The resident received 4 doses of Lorazepam 0.5mg on 03/28/21 at 8:05am, 8:07am, 6:10pm,

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and 9:41pm.

Review of Resident #4's accident/incident (A/I) report dated 03/28/21 at 9:06pm revealed:
-The resident was sitting in a chair in the hallway unresponsive.
-The resident was pale and drooling.
-The resident was taken to the emergency room (ER) by emergency medical services (EMS) at 8:50pm.

Review of Resident #4's ER visit notes dated 03/28/21 revealed:
-When EMS arrived to the facility, the resident was found sitting in a chair in the hallway near the front desk and the resident was not alert.
-Facility staff stated the resident was on his feet and active at 7:30pm, exhibiting normal behavior, then he sat down and appeared to go to sleep around 8:00pm.
-Some 15 to 30 minutes later, they tried to wake the resident to put him to bed but he was unresponsive and staff could not wake him up.
-EMS noted the resident was sitting with his hands in his lap, his head slumped forward, diaphoretic (sweating heavily), and drooling on to the front of his shirt.
-The resident's blood sugar and respirations were normal but his blood pressure was low.
-The resident arrived to the ER at 9:32pm with chief complaint of being unresponsive.
-According to hospital records, the resident had a history of seizures and it was suspected he could have had an unwitnessed seizure.
-The resident "likely" had seizure activity and had chronic kidney disease.

Telephone interview with a medication aide (MA) on 04/01/21 at 4:33pm revealed:
-He thought he could administer Resident #4's

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prn Lorazepam at the same time as the scheduled Lorazepam dose because it was "not a very strong dose".
-Resident #4 tended to wander and argued with other residents.
-Resident #4 would crawl in other residents' bed and cuddled up next to the other residents.
-Resident #4 was "everywhere" and it was hard to keep up with Resident #4.
-When he administered the prn and scheduled Lorazepam at the same time or close together, it was because the resident was "up and doing a lot".
-He tried to keep Resident #4 as calm as he could.
-He never had any issues with administering the prn and scheduled Lorazepam at the same time.
-On 03/28/21, he administered prn Lorazepam and the scheduled Lorazepam at the same time that morning; then he administered another prn Lorazepam at 6:10pm because the resident "started acting out".

Attempted telephone interview on 04/01/21 at 5:00pm with the MA who documented the prn Lorazepam dose on 03/28/21 at 9:41pm was unsuccessful.

Interview with the Care Manager (CM) on 04/01/21 at 11:40am revealed:
-She was not aware Resident #4 was administered 4 doses of Lorazepam on 03/28/21, the same day he was found unresponsive by staff on night shift.
-She was not aware the prn order for Lorazepam needed to include the maximum dosage to be administered in a 24-hour period of time.
-She and the MAs were responsible for clarifying medication orders.
-She would contact Resident #4's mental health

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provider (MHP) to clarify a maximum dosage for the Lorazepam.

Interview with the Administrator on 04/01/21 at 5:30pm revealed:
-She was not aware prn psychotropic medication orders were required to have a maximum dosage to be administered in a 24-hour period of time.
-The CM or MAs should contact the provider for clarification of medication orders.

Telephone interview with Resident #4's MHP on 04/01/21 at 3:05pm revealed:
-Resident #4 wandered "a lot" and had to be redirected by staff.
-Resident #4 was prescribed prn medication to help with agitation.
-The MAs should wait at least 4 to 6 hours after a scheduled dose of Lorazepam was administered before administering prn Lorazepam if needed.
-She was not aware Resident #4 was receiving prn Lorazepam so close to the scheduled doses of Lorazepam.
-The MAs were not supposed to do that; the MAs knew it was a 4-hour window (according to the prn order).
-Administering the scheduled Lorazepam and the prn Lorazepam too close together put the resident at risk of side effects such as sedation.
-She was not aware staff administered 4 doses of Lorazepam to Resident #4 on 03/28/21 when he was found unresponsive by staff.
-Resident #4 had no documented history of seizures and Lorazepam was generally used to treat seizures.
-It was concerning that the resident was found unresponsive after the 4 doses of Lorazepam on 03/28/21 because too much Lorazepam could cause the resident to have low blood pressure, low heart rate, and sedation.

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CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

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D 350	Continued From page 52 -No one from the facility contacted her prior to today, 04/01/21, to clarify the maximum dosage of the prn Lorazepam. -She would revise the Lorazepam orders and lower the dosage that could be administered each day to the resident. Review of a clarification order from Resident #4's MHP dated 04/01/21 revealed: -There was an order to discontinue Lorazepam 0.5mg take 1 tablet every 4 hours prn agitation. -There was an order to start Lorazepam 0.5mg take 1 tablet every 24 hours as needed for agitation (can give for agitation 6 hours after the scheduled dose = not to exceed 1 prn dose in a 24-hour period). -Staff was to monitor for sedation effect, gait disturbances, and contact the MHP immediately. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 350		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 358		

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reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#6, #7) observed during the medication pass including errors with a medication for constipation (#7) and a medication that may decrease the risk of blood clots with COVID-19 infection (#6); and for 1 of 5 residents sampled (#1) for record review who was not administered an antibiotic for infection as ordered.

The findings are:

1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am/9:00am and 11:00am/12:00pm medication passes on 03/30/21.

a. Review of Resident #7's current FL-2 dated 12/21/20 revealed diagnoses included alcohol induced dementia, altered mental status, fall, Vitamin B deficiency, cerebral infarction, muscle weakness, dysphagia, and rhabdomyolysis.

Review of Resident #7's physician's order dated 01/07/21 revealed an order for Miralax take 17 grams (g) once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17 grams that should be used to measure the dosage at the top of the white section of the cap.)

Observation of the 8:00am medication pass on 03/30/21 revealed:
-There was a white section lining the inside of the purple cap on the Miralax bottle.
-There was "17 g" imprinted near the top of the white section and an arrow pointing up to indicate

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the measurement for 17 grams was at the top of the white section inside the cap.
-The medication aide (MA) poured the Miralax powder to the bottom edge of the "17 g" imprint which was approximately 1/8th to 1/4th inch below the top of the white section marking 17 grams.
-The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water.
-The MA mixed the Miralax powder in water and gave it to the resident to take with his oral medications at 8:14am.
-The resident drank all of the water with Miralax but a full 17-gram dosage was not prepared and administered to the resident.

Interview with the MA on 03/30/21 at 1:10pm revealed:
-She usually measured Resident #7's Miralax powder just below the imprint of "17 g".
-She had not noticed the arrow pointing up that indicated the 17-gram marking was at the top of the white inner lining of the cap.

Review of Resident #7's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax, 1 capful (17g) in 8 ounces of water daily scheduled for 8:00am.
-Miralax was documented as administered daily from 03/01/21 - 03/30/21.
-The MA observed during the 8:00am medication pass on 03/30/21 had documented administration of the Miralax 24 of 30 days from 03/01/21 - 03/30/21.

Interview with Resident #7 on 03/30/21 at 3:43pm revealed:
-He usually drank all of the water the MAs gave to

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him when he was administered medications.
-He did not have any current issues with constipation.

Interview with the Care Manager (CM) on 03/30/21 at 1:26pm revealed:
-There was a marking inside the cap of the Miralax bottle that marked 17 grams.
-She expected the MAs to measure the Miralax powder to the marked area inside the cap, which was the top of the white inner lining of the cap.
-She was not aware the MA did not know how to properly measure the Miralax powder.
-Resident #7 was not currently having any issues with constipation to her knowledge.

Interview with the Administrator on 03/30/21 at 1:51pm revealed:
-She was not aware the MA was not measuring the Miralax correctly for Resident #7.
-The MAs should use the proper marking to measure the Miralax powder.

Attempted interview with Resident #7's primary care provider (PCP) on 04/01/21 at 2:53pm was unsuccessful.

b. Review of Resident #6's current FL-2 dated 01/05/21 revealed diagnoses included dementia, localized anemia, and muscle weakness.

Review of Resident #6's physician's order dated 02/28/21 revealed an order for Aspirin 325mg once daily for 30 days for COVID-19 infection. (Aspirin may decrease the risk of blood clots with COVID-19 infection. Enteric Coated Aspirin has a special coating to prevent stomach irritation and upset and reduce the risk of stomach bleeding. Enteric Coated Aspirin should not be crushed or chewed to maintain the protective coating of the

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tablet.)

Review of Resident #6's standing house orders dated 02/19/21 revealed all medications may be given by mouth and/or crushed (check do not crush list) and placed in applesauce or pudding unless otherwise noted.

Observation of the 8:00am medication pass on 03/30/21 revealed:
-The medication aide (MA) prepared morning medications for Resident #6, including one Enteric Coated Aspirin 325mg tablet.
-The MA crushed all of Resident #7's oral medications, including the Enteric Coated Aspirin, mixed them in yogurt and administered them to the resident at 7:55am.

Observation of Resident #6's medications on hand on 03/30/21 revealed:
-There was a supply of Enteric Coated Aspirin 325mg tablets dispensed on 03/01/21.
-There was an auxiliary label with "Don't chew/crush - Swallow whole" on the medication label.

Review of Resident #6's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Enteric Coated Aspirin 325mg take 1 tablet every day for 30 days for COVID-19 infection scheduled for 8:00am.
-Enteric Coated Aspirin was documented as administered daily from 03/03/21 - 03/29/21.
-There was no information noted on the eMAR to indicate the medication should not be crushed.

Review of the facility's Do Not Crush (DNC) medication list revealed:
-Enteric Coated medications were designed to

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pass through the stomach with the drug being released in the intestines to prevent destruction of the drug by stomach acids; prevent stomach irritation; and delay the onset of action.
-Enteric Coated Aspirin was included on the list as a medication that should not be crushed due to the enteric coating.

Interview with the MA on 03/30/21 at 1:15pm revealed:
-The facility had a DNC list in the medication cart as a guide.
-If a medication was included on the DNC list, the MAs were not supposed to crush them.
-Resident #6 did not do well with swallowing pills whole because the resident would hold them in her mouth if they were not crushed.
-She was aware Resident #6's Aspirin was enteric coated and should not be crushed.
-She did not think about it until after she had already crushed the Enteric Coated Aspirin and administered it to Resident #6 that morning on 03/30/21.
-She usually let the Enteric Coated Aspirin "melt" in the resident's mouth.
-When questioned about how an enteric coated tablet could dissolve in the resident's mouth, the MA then stated she sometimes put the whole tablet in applesauce and administered it to the resident.

Interview with the Care Manager (CM) on 03/30/21 at 1:26pm revealed:
-There was a DNC list in the medication cart and some medications also had a DNC sticker on the medication label.
-A medication listed on the DNC list or marked on the label as DNC should not be crushed.
-The MAs were supposed to refer to the DNC list before crushing medications.

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-The MAs should notify her or the primary care provider (PCP) if a medication could not be crushed so an alternate formulation could be ordered and administered.
-Resident #6's Enteric Coated Aspirin should not have been crushed.
-Resident #6 had not complained of any stomach irritation to her knowledge.

Interview with the Administrator on 03/30/21 at 1:51pm revealed:
-There should be an order to crush medications and there should be a DNC list posted at the nurses' station.
-A medication should not be crushed if it is included on the DNC list.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

Attempted interview with Resident #6's PCP on 04/01/21 at 2:53pm was unsuccessful.

2. Review of Resident #1's current FL-2 dated 07/14/20 revealed diagnoses included dementia, muscle weakness, hypothyroidism, major depressive disorder, pulmonary heart disease, cataracts, history of left hip fracture, and gastrointestinal bleed.

Review of Resident #1's physician visit note dated 03/02/21 revealed:
-The resident had a new lacrimal cyst on the lacrimal gland.
-The cyst would affect eye sight if not treated.
-The resident required an ophthalmology referral for infected lacrimal cyst.
-The resident required antibiotic therapy to treat her infected lacrimal cyst.

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D 358	Continued From page 59 Review of a physician order dated 03/05/21 revealed an order for Doxycycline 100mg, 1 tablet twice a day for 7 days for infected lacrimal cyst of the right eye (Doxycycline is an antibiotic used to treat infection). Review of Resident #1's March electronic medication administration record (eMAR) from revealed: -There was an entry for Doxycycline 100mg, 1 tablet twice a day for 7 days that started on 03/05/21 and ended 03/11/21. -Doxycycline 100mg was documented as administered twice a day from 03/07/21 to 03/11/21. Observation of Resident #1's medications on hand on 03/30/21 at 3:52pm revealed there was no Doxycycline present. Review of the pharmacy's Delivery Record Receipt dated 03/05/21 revealed 14 tablets of Doxycycline 100mg were delivered to the facility on 03/05/21 at 6:25pm. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/21/21 at 09:15am revealed: -The pharmacy dispensed 14 doses of Doxycycline for Resident #1 on 03/05/21. -The Doxycycline was delivered to the facility the evening of 03/05/21. Interview with a medication aide (MA) on 03/31/21 at 10:50am revealed: -She remembered administering Resident #1's antibiotic but did not think the medication arrived until 03/06/21 late in the evening, so it wasn't started until 03/07/21.	D 358		

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D 358	Continued From page 60 -When a new prescription was ordered, the MA or Care Manager (CM) confirmed it on the eMAR once the medication was delivered to the facility. Interview with a MA on 04/01/21 at 10:52am revealed: -She remembered administering Resident #1's antibiotic and remembered giving her the final pill in the package. -Based on her review of the eMAR she believed that was on 03/11/21. Interview with the CM on 03/30/21 at 4:38pm revealed: -The pharmacy was responsible for entering new orders onto the eMAR. -Either a MA or the CM confirmed the order when the medication was delivered to the facility. -She did not know why Resident #1 only received 10 of the 14 doses of her antibiotic. -In reviewing the eMAR it looked as though she only received partial doses of the prescribed antibiotic. -It was important Resident #1 received the entire dose of the antibiotic prescribed by the primary care physician (PCP). Attempted telephone interview with Resident #1's PCP on 04/01/21 at 2:53pm was unsuccessful. Attempted telephone interview with Resident #1's Ophthalmologist on 04/01/21 at 10:15am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 358		

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D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides (MA) observed residents actually taking their medications as evidenced by housekeeping staff finding medications on the floor when cleaning on multiple occasions including Vitamin D-3 and Vitamin B-12 tablets for 1 of 1 sampled residents (#11) on 04/01/21. The findings are: Review of Resident #11's current FL-2 dated 11/30/20 revealed: -Diagnoses included dementia, thrombocytopenia, hypertension, hypothyroidism, major depressive disorder, nausea with vomiting, epigastric pain, and anxiety disorder. -The resident's orientation status was not addressed. Review of Resident #11's current physician's orders dated 03/23/21 revealed: -There was an order for Vitamin D-3 25mcg, 1 tablet every morning. (Vitamin D-3 is used to	D 366		

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treat Vitamin D deficiency.)
-There was an order for Vitamin B-12 1,000mcg, 1 tablet every morning. (Vitamin B-12 is used to treat Vitamin B-12 deficiency).

Interview with a housekeeper on 04/01/21 at 10:43am revealed:
-She found 2 pills on the floor in front of the night stand by the bed in Resident #11's room that morning on 04/01/21.
-She was sweeping in Resident #11's room when she found two round pills; she disposed of them in the housekeeping cart.
-She found pills on the floor "almost every day" while cleaning the facility.
-Some of the pills she found had been stepped on and were crushed powder.
-She did not report finding the pills on the floor to anyone because she did not know she was supposed to report it.

Interview with a second housekeeper on 04/01/21 at 10:43am revealed:
-She had been finding pills on the floors since she started working at the facility about 40 days ago.
-Some pills she found might be behind the beds; and some pills were whole tablets and some were broken.
-She had also observed a white cream in a plastic medication cup sitting on dressers in the residents' rooms.
-She last found pills on the floor while sweeping that morning, 04/01/21, but she could not recall which room.
-She did not report findings pills on the floor because she did not know she was supposed to report it.

Observation of a housekeeping cart on 04/01/21 at 11:30am revealed:

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-There were two round tablets noted in the bottom of the dustpan used by housekeeping staff.
-One tablet was white with no imprint code.
-The other tablet was white with pink stains and there were purple specks in the tablet and no imprint code.
-The tablets were retrieved from the dustpan with the use of a glove and paper towel for identification and and proper disposal.

Interview with the medication aide (MA) on 04/01/21 at 12:10pm revealed:
-Resident #11 usually took 10 to 15 minutes to swallow her pills.
-She usually administered about 3 pills at a time to Resident #11 so the resident did not cough or choke on the pills.
-The resident did not want her pills to be crushed most of the time.
-She never had Resident #11 open her mouth so she could check to make sure the resident swallowed all the pills.
-She administered Resident #11's medications whole that morning on 04/01/21 while the resident was sitting in a chair in her room.
-The other day (no date specified), Resident #11 tried to put the pills in her pocket and she had to redirect the resident to take the medications.

Review of Resident #11's March 2021 and April 2021 electronic medication administration records (eMARs) revealed:
-There was an entry on each eMAR for Vitamin D-3 25mcg, 1 tablet every morning scheduled for administration at 8:00am.
-Vitamin D-3 25 mcg was documented as administered at 8:00am from 03/01/21 - 04/01/21.
-There was an entry on each eMAR for Vitamin B-12 1,000mcg, take 1 tablet every morning

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scheduled for administration at 8:00am.
-Vitamin B-12 1,000mcg was documented as administered at 8:00am from 03/01/21 - 04/01/21.

Observation of Resident #11's multi-dose medication package on 04/01/21 at 12:15pm revealed:
-The description of Vitamin D-3 25mcg medication was a natural, round tablet.
-The Vitamin D-3 tablet in the multi-dose package matched the white, round tablet found by housekeeping staff in Resident #11's room on 04/01/21.
-The description of Vitamin B-12 1,000mcg medication was a pink, round tablet.
-The Vitamin B-12 tablet in the multi-dose pack was pink with purple specks and matched the other tablet found by housekeeping staff in Resident #11's room on 04/01/21.

Interview with the Care Manager (CM) on 04/01/21 at 12:20pm revealed:
-The MAs should observe residents take and swallow their medications before they went to the next resident.
-If a resident was having trouble swallowing or refusing to take their medications, the MAs should report it to her and the primary care provider (PCP).
-She was not aware housekeeping staff had found pills on the floors of the facility when cleaning as it had not been reported to her.
-She was concerned if pills were being found on the floors, residents were not getting their medications or other residents could pick up the pills and take them.
-No medications, including creams should be left in a resident's room especially since the facility had all dementia residents.

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D 366	Continued From page 65 Interview with the Administrator on 04/01/21 at 12:52pm revealed: -Staff had not reported finding any medications on the floor to her. -She expected the MAs to actually observe the residents take and swallow their medications. -The MAs needed to check to make sure the residents were swallowing their medications. Based on observations, interviews, and record review, it was determined Resident #11 was not interviewable. Attempted telephone interview with Resident #11's PCP on 04/01/21 at 2:53pm was unsuccessful.	D 366		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication passes on 03/30/21 by 1 of 2 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering oral medications, including feeding crushed medications to two residents and punching medications into her bare, ungloved hands.	D 371		

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D 371	Continued From page 66 The findings are: Review of the facility's Infection Prevention Practices guideline for medication administration revealed: -Use sanitary technique when pouring and preparing medications into appropriate container. -Do not touch or handle medications, but pour medication from the original medication container into a new, appropriate medication container; give the new container to the resident. -Never use your own hands to administer medications and never require a resident to have to use his/her own hands to receive medications. Observation of the a medication aide (MA) on 03/30/21 from 7:45am - 8:00am revealed: -At 7:45am, the MA was on the 300 hall with the medication cart and then pushed the medication cart to the 200 hall. -There was a bottle of hand sanitizer with a pump dispenser on the medication cart over half full of sanitizer. -The MA started to prepare medications for a resident on the 200 hall. -The MA did not sanitize or wash her hands prior to starting the medication pass for the 200 hall residents. - The MA prepared 6 oral medications by punching the medications from the dose packs into her bare, ungloved hands. -The MA put the medications into a plastic sleeve, crushed them, and stirred the crushed medications into some strawberry yogurt. -The MA then fed the resident the crushed medications with a spoon at 7:52am. -The MA did not sanitize or wash her hands prior to, during, or after administering/feeding the crushed medications in yogurt to the resident and	D 371		

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D 371	Continued From page 67	D 371		

she was not wearing gloves.
- The MA prepared 5 oral medications for a second resident by punching the medications from the dose packs into her bare, ungloved hands.
-The MA put the medications into a plastic sleeve, crushed them, and stirred the crushed medications into some strawberry yogurt.
-The MA then fed the second resident the crushed medications with a spoon at 7:55am.
-The MA did not sanitize or wash her hands prior to, during, or after administering/feeding the crushed medications in yogurt to the resident and she was not wearing gloves.
-The MA was touching the top surface and the drawers of the medication cart, the computer on the medication cart, and doors when entering residents' rooms during this time.
-The MA then pushed the medication cart to another resident's room to continue the morning medication pass without washing or sanitizing her hands.

Interview with the MA on 03/30/21 at 12:20pm revealed:
-She usually washed or sanitized her hands after every 2 residents as she passed medications.
-If she did tasks such as eye drops or fingerstick blood sugars, she would wash or sanitize immediately after doing those tasks.
-She usually punched the medications from the dosage packs into her bare, ungloved hands because it was a "habit".

Interview with the Care Manager (CM) on 03/30/21 at 1:26pm revealed:
-The facility's policy was for the MAs to sanitize their hands between every resident during the medication pass and wash with soap after every third resident.

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D 371	Continued From page 68 -The MAs should punch the medications into a medication cup, not their bare hands. -She expected the MAs to sanitize after each resident and the MAs should not punch the medications into their bare hands. -If a MA was going to punch medications into their hands, the MA should wear a clean pair of gloves for each resident. Interview with the Administrator on 03/30/21 at 1:51pm revealed: -The MAs should sanitize their hands between every resident and wash their hands after every third resident. -The MAs should punch the medications into the medication cup, not their bare hands.	D 371		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the facility with a census of 46 residents were met for 5 of 12 shifts sampled from 03/12/21-03/15/21.	D 465		

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D 465	Continued From page 69 The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 60 residents in a special care unit (SCU) facility. Review of the facility's resident census reports dated 03/12/21- 03/15/21 revealed there was a census of 46 residents on each of those dates, which required 46 staff hours on first and second shift and 36.8 staff hours on third shift. Review of the employee time cards dated 03/12/21 revealed there was a total of 44.15 staff hours provided on first shift with a shortage of 1.85 hours. Review of the employee time cards dated 03/14/21 revealed there was a total of 37.46 staff hours provided on second shift with a shortage of 8.31 staff hours. Review of the employee time cards dated 03/15/21 revealed: -There was a total of 42.5 staff hours provided on first shift with a shortage of 3.5 hours. -There was a total of 39 staff hours provided on second shift with a shortage of 7 hours. -There was a total of 24 staff hours provided on third shift with a shortage of 12.8 hours. Interview with a housekeeping staff on 03/30/21 at 11:45am revealed: -There were times when she could not find any staff because of short staffing. -It bothered her when she saw a resident who needed help but she could not help them and I could not find anyone to help them either. -This was worse when she would see them about	D 465		

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D 465	Continued From page 70 to fall. Interview with a medication aide (MA) on 04/01/21 at 10:13am revealed: -She usually worked first shift but worked at night because the facility was short staffed. -On 03/15/21, the facility was short staffed at night and she signed up to help them. -Staff were overwhelmed due to short staffing. -There was not enough staff working in the facility. -If the MA working today (03/31/21) would not have signed up to work, the facility would have been short staffed. -The facility had been short staffed more than a month. Interview with another MA on 04/01/21 at 10:43am revealed: -The facility was always short staffed at night every other week. -When the facility was short staffed, it was "difficult to lookout for residents, whatever happens, happens." -When the facility was short staffed, staff were not able to give residents showers because there would not be anyone on the floor. -There was usually 1 MA and 1 PCA or 1 MA on duty at night. -There should have been 2 MAs and 3 PCAs scheduled at night. -The facility had been short staffed for months. -She had expressed her concerns of the facility being short staffed with the Administrator. Interview with a resident's power of attorney revealed that there was a "big turn over" with staff and caused short staffing. Interview with the Care Manager (CM) on	D 465		

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D 465	Continued From page 71 04/01/21 at 10:57am revealed: -She was responsible for the schedule. -She determined how many staff were needed based on the census in the facility. -She was not aware the facility was short staffed 03/12/21- 03/15/21. -She was responsible for finding coverage for the schedule when the facility was short staffed. -However, depending on the time staff called out, they were responsible for finding their own coverage for their shift. -She had worked in the facility when the schedule was short staffed. -When the facility was short staffed, someone would assist the floor staff or sign up for an extra shift. -Currently, the facility was not fully staffed but that had been improving. -She hired new employees recently. Interview with the Administrator on 04/01/21 at 2:56pm revealed: -She was aware the facility was short staffed 03/12/21-03/15/21 because she had a state agency come into the facility to assist with staffing. -The CM was responsible for the schedule. -She did not review the schedule when the CM completed it. -The CM would post shifts and days that were short staffed to allow the employees to volunteer to work extra days. -She was aware the facility was currently short staffed.	D 465		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints	D 482		

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D 482	Continued From page 72 And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids,	D 482		

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providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure physical restraints were used according to physician's orders for 1 of 1 residents sampled (#2) including use only after an assessment and care planning process had been completed through a team process, a written order was received from a physician for a geri-chair and a signed consent the resident's legal representative was obtained and that the restraints were checked every 30 minutes and released every two hours.

The findings are:

Review of Resident #2's current FL-2 dated 08/12/20 revealed:
-Diagnoses included Alzheimer's dementia with behavioral disturbance, hypertension, hemiplegia, and muscle weakness.
-The resident was constantly disoriented.
-The resident was non-ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required staff assistance with eating, toileting, ambulation, bathing, dressing, grooming and transfer.
-The resident was required total care.
-The section for restraints was blank.

Review of Resident #2's current resident care plan signed and dated 03/29/21 revealed:
-The resident was uncooperative and resistant to care.
-The resident was ambulatory with a wheelchair

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requiring staff assistance.
-The resident was incontinent of bowel and bladder.
-The resident required staff to feed for all meals and snacks.
-The resident required total staff assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident had "special management needs" with geriatric chair (high back reclining wheelchair) and 2-person assistance as needed.

Review of Resident #2's physician's order dated 09/23/20 for physical restraint revealed:
-There was an order to supply Resident #2 geri chair that reclines.
-The diagnoses needed for the physical restraint included: fall, essential hypertension and advance dementia.

Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 12/31/20 revealed:
-The LHPS tasks included ambulation with assistive device and transferring.
-Staff must transfer the resident.
-Resident #2 used a wheelchair for mobility and was able to propel self.
-The nurse's recommendation was to continue the current plan of care.

Observation of Resident #2's room on 03/29/21 at 2:05pm revealed Resident #2 was in her geriatric chair reclined back.

Observation of Resident #2 on 03/29/21 at 2:27pm revealed the resident was sitting reclined in her geriatric chair in her room and leaning to the left side "reaching" for the floor.

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D 482	Continued From page 75 Observation of Resident #2's room on 03/29/21 at 4:15pm revealed: -Resident #2 was in her geriatric chair reclined back. -There was a sign posted in her room over the thermostat near the head of Resident #2's bed that stated, "ATTENTION!! When sleeping or tired recline chair back or lay her down in the bed. The family has seen the resident bent over in the chair sleeping. Please recline chair back or lay her down to rest." -The sign was dated 03/25/21. Observation of Resident #2 on 03/30/21 at 7:30am revealed the resident was sitting up in her geriatric chair in her room. Observation of Resident #2 on 03/31/21 at 9:30am revealed: -The resident was reclined in her geriatric chair in her room. -She would reach down to the floor from her left side. Observation of Resident #2 on 03/31/21 at 9:57am revealed the resident was sitting up in her geriatric chair in her room. Interview with a PCA on 03/31/21 at 10:30am revealed: -Resident #2 had frequent incontinent episodes. -She tried to check on her every hour or so or everytime she came by Resident #2's room. -She would recline Resident #2 in her chair if she was sleepy. Observation of Resident #2 on 04/01/21 at 8:10am revealed the resident was sitting up in her geriatric chair in the hallway outside of her room.	D 482		

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D 482	Continued From page 76 Interview with a housekeeping staff member on 04/01/21 at 11:05am revealed: -She very seldom saw Resident #2 in bed. -She was most always in her reclining chair. -She was usually awake sitting up in the chair but a few times she had seen Resident #2 asleep leaned over in her chair. The physical restraint assessment and care planning process and the signed consent of the resident's legal representative for Resident #2 was requested on 04/01/21 at 10:01am and again at 3:00pm but was not provided by the time of exit. Interview with Resident #2's family member on 03/30/21 at 12:21pm revealed: -She had seen Resident #2 during "window visits". -She had seen Resident #2 sitting in her geriatric chair bent over sleeping. -She was afraid Resident #2 would fall forward out of the chair. -She called the Administrator and requested that the chair be reclined or have Resident #2 to be put to bed when tired or sleeping. -She had not had to sign anything regarding the chair nor involved in a care plan meeting. Interview with the Administrator on 04/01/21 at 12:17pm and 4:03pm revealed: -She was not aware the geriatric chair was a restraint. -Resident #2's family member requested on 03/25/21 for the geriatric chair be reclined. -There was not a consent signed by the family member since the Administrator did not consider the chair to be a restraint. -The assessment and care plan for use of the geriatric chair was not done since she did not	D 482		

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D 482	Continued From page 77 consider the chair to be a restraint. -She had not gotten a restraint order for the geriatric chair. -Staff were not supposed to recline the chair unless Resident #2 was sleeping or tired. -She was not aware staff were reclining the chair for Resident #2 while she was awake. Attempted interview with Resident #2's Primary Care Provider on 04/01/21 at 2:53pm was unsuccessful.	D 482		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents were treated with respect, dignity, consideration, and right to privacy as related to two male residents (#4, #9) wandering throughout the facility and entering other residents' rooms uninvited and sleeping in the residents' beds, sitting in their chairs, and going through other residents' personal belongings. The findings are: Confidential staff interview revealed: -She witnessed two male residents wander into other residents' rooms. -The two male residents would go into male and female residents' rooms.	D911		

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D911	Continued From page 78 Interview with a resident on 04/01/21 at 2:38pm revealed: -Two male residents, that were not his roommate, wandered into his room during the day and at night. -The two male residents wandered into his room at least three times a day. -The two residents who wandered into his room never became physically aggressive with him but sometimes they were verbally aggressive and yelled at him. -He was upset about the two males wandering into his room. -He did not like them in his "personal space". -He did not want them to steal from him. 1. Review of Resident #4's current FL-2 dated 07/08/20 revealed: -Diagnoses included vascular dementia, syncope with history of falls, hypertension, benign prostatic hypertrophy, gout, and electrolyte imbalances. -The resident was constantly disoriented and wandered. Observation of Resident #4 on 03/29/21 at 2:05pm revealed: -The resident was lying in bed in his room and said "alright" when spoken to. -The resident mumbled and talked incoherently. Review of Resident #4's progress note dated 10/07/20 at 10:16pm revealed: -Resident #4 got into an altercation with another resident which resulted in Resident #4 getting hit by an object. -The resident did not appear to have any injuries. -Staff would continue to closely monitor the resident for any changes. Telephone interview with a medication aide (MA)	D911		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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on 03/31/21 at 11:55pm revealed:
-On 10/07/20, Resident #4 walked into another resident's room (did not recall who) and got into an altercation with the other resident.
-Resident #4 was hit by an object (could not recall what the object was) and she thought he was hit on the forehead.

Review of Resident #4's progress note dated 10/11/20 at 5:37am revealed the resident had been awake all night going into other residents' rooms.

Review of Resident #4's progress note dated 02/05/21 at 2:38pm revealed:
-Resident #4 went into another resident's room and the other resident was trying to shut the door on Resident #4 to keep him out.
-The door was closed on Resident #4's left hand.

Telephone interview with the same MA on 03/31/21 at 11:55pm revealed:
-On 02/05/21, Resident #4 wandered into another resident's room (did not recall who) and Resident #4's hand was injured with the door.
-The resident's hand was not bruised or broken.
-Residents had voiced concerns to her about not wanting Resident #4 in their rooms.
-She had not observed Resident #4 touch anyone inappropriately and no residents had voiced concerns about that.

Interview with a second MA on 03/31/21 at 3:50pm revealed:
-On 03/24/21, she found Resident #4 in another resident's room so she directed him out of the room and sat him in a chair.
-She went to complete some personal care duties and she heard a loud noise.
-Resident was back in the other resident's room

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	HAL051041	A. BUILDING: _____ B. WING _____	04/01/2021

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and sitting on the floor.
-She and the MA checked Resident #4 but he had no injuries.
-She was concerned the other resident may have pushed Resident #4 causing the fall because the other resident did not want Resident #4 in his room.
-Resident #4 would sometimes grab other residents' arms to try to get the residents' to go with him.
-She had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to her.

Confidential staff interview revealed:
-A female resident notified her that Resident #4 went into her room and grabbed her inappropriately.
-She heard the female scream for help when Resident #4 went into her room while she was feeding a resident across the hallway.
-Resident #4 pulled the staff person into a resident room and attempted to push the staff person onto the bed.
-The staff person was able to get away from Resident #4 but was concerned that residents may not be able to get way from Resident #4 as easily.

Interview with the female resident on 03/29/21 at 10:13am revealed:
-The resident had come in her room and caught "people" stealing her blanket 3 or 4 times.
-There was a man who came in the resident's room and "they let him get by with it".
-The resident denied being touched inappropriately by anyone.

Telephone interview with a third MA on 03/31/21 at 11:55pm revealed:

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D911	Continued From page 81 -She had observed other male residents, including Resident #4, wander into the female resident's room. -Staff would try to redirect the residents out of the female resident's room. -She had not observed any residents touch the female resident inappropriately. -The female resident had not voiced any concerns or complained about being touched by other residents to her. Observation on 03/30/21 at 3:44pm revealed Resident #4 was not in his room. Observation on 03/30/21 at 3:48pm revealed the MA found Resident #4 in another resident's room and the MA redirected Resident #4 to his room. Observation of Resident #4 on 03/31/21 at 8:12am revealed: -Resident #4 was in another male resident's room down the hall from his room. -Resident #4 was lying on the bed near the door with his eyes closed. -The two male residents who resided in the room were also sitting in the room. Observation of Resident #4 on 03/31/21 at 9:40am revealed: -Resident #4 was walking down the hall when he walked into another resident's room. -The male resident who resided in that room attempted to stop Resident #4 from entering his room by blocking Resident #4 with his rolling walker. -Two personal care aides (PCAs) redirected Resident #4 and assisted him to his room. Interview with a male resident on 04/01/21 at 12:14pm revealed:	D911		

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D911	Continued From page 82 -Resident #4 wandered into his room all the time. -He and his roommate did not like Resident #4 coming in their room. -If his roommate was in the room when Resident #4 tried to enter, the roommate would stop Resident #4. -If he was alone, he would call for the "nurse" to come get Resident #4. -Resident #4 invading his personal space made the resident feel like ["explicative"]. Observation of the men's hall on 04/01/21 at 2:36pm revealed: -Resident #4 was walking down the hallway, dragging a blanket between his feet. -Resident #4 was attempted to walk into another resident's room. -The Maintenance Director stopped Resident #4 before he could get into the other resident's room. -The Maintenance Director called for the PCA that was delivering snacks for assistance. -The PCA redirected Resident #4 and escorted him back to his room down the hallway. Observation of the Administrator's office on 04/01/21 at 10:02am revealed: -Resident #4 walked into the office and picked up a box of paper clips off her desk. -The Administrator redirected Resident #4 and assisted him back into the hallway. Confidential staff interview revealed: -Resident #4 tried to get in bed with female residents. -Resident #4 would go to sleep in other resident's beds and the PCAs would just let him sleep without redirecting the resident back to his room. -Resident #4 "got lost" every day and staff would find Resident #4 asleep in another resident's room.	D911		

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D911	Continued From page 83 Confidential interview with a second staff revealed: -Resident #4 would fall asleep in other residents' rooms. -Residents (male and female) had complained to staff about Resident #4 going into their rooms. -The residents did not like Resident #4 invading their personal space. Interview with a fourth MA on 03/31/21 at 3:26pm revealed: -Resident #4 wandered into other residents' rooms and when she saw him doing this, she would redirect him. -She had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to her. Interview with a fifth MA on 03/31/21 at 3:34pm revealed: -Resident #4 wandered into other residents' rooms and she would redirect him. -Most of the time when she found Resident #4 in other residents' rooms, he was either laying down or plundering through the other residents' belongings. -She had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to her. -About 1 to 2 months ago (could not recall date), she found Resident #4 in a female resident's (could not recall which resident) room on the women's hall. -The female resident was asleep in bed and Resident #4 was curled up at the foot of the bed asleep. -She guided Resident #4 out of the room. -She had also found Resident #4 in bed with a male resident and both were asleep but she could	D911		

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not recall when or which resident.

Interview with a PCA on 03/29/21 at 2:05pm revealed:
-Resident #4 "loves females" and would go to the women's hall and try to go in their rooms.
-Resident #4 walked up to female residents and tried to get them to go with him.
-The female residents did not like Resident #4 in their rooms.
-He had not observed Resident #4 touch anyone inappropriately and there had been no concerns reported to him.

Telephone interview with a sixth MA on 04/01/21 at 4:33pm revealed:
-Resident #4 wandered into other residents' rooms and the other residents got upset and irritated with Resident #4 because they did not want him in their rooms.
-Resident #4 would crawl in other residents' bed and cuddled up next to the other residents.

Telephone interview with Resident #4's family member on 03/31/21 at 5:50pm revealed:
-The resident wandered into other residents' rooms and other residents did not like it.
-Prior to the COVID-19 pandemic, she would visit the resident and find him in other residents' room lying in their beds.

Refer to interview with the Administrator on 04/01/21 at 5:15pm.

2. Review of Resident #9's current FL-2 dated 06/01/20 revealed:
-Diagnoses included dementia, hypertension, cardiovascular health, history of stroke, rhinorrhea, type 2 diabetes mellitus, gastrointestinal esophageal reflux disorder,

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D911	Continued From page 85 chronic pain, history of Vitamin D and Vitamin B12 deficiency, erectile dysfunction, tinea pedis and poor balance. -The resident was documented as constantly disoriented. -The resident documented as a wanderer. Observation on 03/29/21 at 11:06am on the women's hall revealed: -A female resident yelled loudly a few times in a distressed voice, "there's a man in my room". -Resident #9 was sitting in the resident's recliner. -After hearing the female resident yell, staff came to the resident's room and redirected Resident #9 from the room. Interview with the female resident on 03/29/21 at 11:06am revealed that was not the first time she had caught Resident #9 in her room and she did not like him being in her room. Observation of Resident #9 on 03/31/21 at 1:05pm revealed: -There was heard a female voice yelling "HELP get out of my room". -Resident #9 was observed exiting the same female resident's room (from 03/29/21 at 11:06am). Interview with personal care aide (PCA) on 03/29/21 at 11:00am revealed Resident #9 was hard to keep up with because he was always walking. Telephone interview with Resident #9's mental health provider (MHP) 04/01/21 at 3:02pm revealed she had observed Resident #9 wander in and out of residents' rooms during her visits at the facility.	D911		

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D911	Continued From page 86 Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable. Refer to interview with the Administrator on 04/01/21 at 5:15pm. _____ Interview with the Administrator on 04/01/21 at 5:15pm revealed she was concerned about residents wandering into other residents' room because residents had a right to their own space.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to supervision and medication orders. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 9 residents sampled (#1, #4, #9) including a resident who eloped twice within 4 days resulting in an emergency room (ER) visit for facial abrasions (#9); a resident who had 3 falls with injuries resulting in a fractured left wrist, a head hematoma, and a laceration above the right	D912		

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D912	Continued From page 87 eye (#1); and a resident who wandered into other residents' rooms resulting in altercations with other residents and the resident being hit by an object and the resident's hand being injured when another resident shut it in the door (#4). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#4) who had orders to receive a controlled substance used to treat anxiety and agitation on a scheduled and prn (as needed) basis resulting in the resident receiving doses too close together. [Refer to Tag 270, 10A NCAC 13F .1002(a) Medication Orders (Type B Violation)].	D912		